STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 01 B. WING	09/04/2012

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NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

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K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/04/12 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Norwood Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000)	K0000	This plan of correction is the facility's credible allegation of compliance.Preparation and /or execution of this plan of correction does not constitute admission or agreement by provider to the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor. Battery operated smoke detectors went installed in the resident rooms. The facility has a capacity of 88 and had a census of 62 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were the electrical room where the generator switch is located, a detached garage used for storage of maintenance equipment and parts, a detached shed used for storage of lumber and another detached shed used for storage of kitchen equipment. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/10/12.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 laundry rooms, a hazardous area, would self close and latch into the door frame. This deficient practice was not in a resident care area but could affect the facility staff in the service hall. Findings include: Based on observation with the Administrator on 09/04/12 at 3:15 p.m., the soiled linen corridor door entering the laundry room did self close, but it failed to latch into the door frame. This was acknowledged by the Administrator at the time of observation.	K0029	Corrective action for residents affected:No residents were affected..Other resident's having the potential to be affected:The facility shall ensure all fire doors secure properly in order to ensure fire management is maintained. The Maintenance Supervisor [MS] is adjusting the door to ensure it securely latches.Measures to ensure practice does not reoccur: The MS will complete a preventive maintenance check on all facility doors to ensure each secures properly. Any that do not secure will be repaired immediately or within 72 hours for doors requiring more extensive repair. These checks will be at least monthly.This corrective action will be monitored by:The MS will complete a monthly PM checklist. His review and all repairs will be identified and submitted to the Administrator for review. This monitoring will be	10/03/2012

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	3.1-19(b)		reviewed by the QA Committee at least monthly for 6 months.	

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets on the 200 hall was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 14 residents on the 200 hall. Findings include: Based on observation with the Administrator on 09/04/12 at 2:06 p.m., the 200 hall fire doors failed to latch into the frame. Based on an interview with the Administrator at the time of observation, these doors were	K0044	Corrective action for resident's affected:The facility shall ensure all fire doors close and latch properly. The MS checked this door immediately after reported on 9/4/12. The door properly latched at that time. Other resident's having the potential to be affected:The facility shall ensure all facility fire doors close and latch properly. The MS shall check all fire doors at least monthly, all doors will be kept lubricated. Measures to ensure practice does not reoccur:The MS will check all fire doors monthly, documenting these checks on a PM Checklist. All doors will be kept lubricated at that time. Any repairs must be completed immediatley or within 72 hours for repairs requiring more involved repair work.This corrective action will be monitored by:The MS will complete a Monthly PM check of all facility doors. This review will be reported to the Administrator and reviewed by the QA Committee for 6 months.	10/03/2012

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	confirmed to be fire doors. 3.1-19(b)			

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K0048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Administrator and the Director of Maintenance on 09/04/12 at 4:25	K0048	Corrective action for resident's affected:The facility shall ensure the Emergency Preparedeness Plan [EPP] identifies each type of fire extinguisher throughout the facility including the kitchen K-class in relationship with the kitchen hood extinguishing system.Other residents having the potential to be affected:same as aboveMeasures to ensure practice does not reoccur:The MS shall ensure the Administrator reviews all related changes to the EPPand at least annually all staff will be in-serviced on all fire extinguisher types including the kitchen K-class and the relationship to the kitchen hood extinguishing system.This corrective action will be monitored by:The MS will update the EPP at least annually and present to the Administrator for review. This shall be further monitored by the QA Committee at the point of any EPP policy/procedural change or at least annually.	10/03/2012

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	p.m., the "Emergency Preparedness Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Administrator and the Director of Maintenance at the time of record review. 3.1-19(b)			

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K0056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 2 electrical rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry-type electrical equipment is used. (c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (d) No combustible storage is	K0056	Corrective action for resident's affected: While it was not confirmed at the time of the survey, the electrical room does not require a sprinkler system as it has walls and ceilings which are [2] hour fire-rated and a fire door. This fire door existed at the time of the survey but may have been missed as it was was open at that time. A sprinkler head was connected to the sprinkler system on 9/26/12 ensuring this deficiency was corrected.Other residents having the potential to be affected:same as above. Measures to ensure practice does not reoccur:The MS shall review all facility rooms at least [1] time per month for a spirnkler head. Any issues will be presented to the AdministratorThis corrective action will be monitored by:The Administrator shall review this	10/03/2012

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	permitted to be stored in the room. This deficient practice could affect all 62 resident should there be a fire in this electrical room where the emergency generator transfer switch preventing the facility from switching to emergency power. Findings include: Based on an observation with the Administrator on 09/04/12 at 2:27 p.m., the electrical room where the generator transfer switch is located lacked sprinkler coverage. The electrical room lacked a door and the Administrator could not confirm the walls and ceiling provided a two hour enclosure. 3.1-19(b) 3.1-19(ff)		with the QA Committee [1] time and additionally for [6] months if any further problems are identified.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to maintain 1 of 1 K-class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This	K0064	Corrective action for resident's affected:1]A placard was placed above K-Class fire extinguisher in the kitchen that reads "Warning In Case of fire, use this extinguisher after fixed suppression system has been activated". All Dietary staff will be trained by 10/3/12 related to this posting/procedure.2] One fire extinguisher had not been inspected. This was immediately corrected.Other residents having the potential to be affected:Same as aboveMeasures to ensure practice does not reoccur:1] The Administrator has observed and ensured the posting was properly mounted. The Administrator shall monitor to ensure the follow- up training has been completed.2 The Administrator shall check each fire extinguisher by 10/3 and randomly each month thereafter to ensure they have been inspected timely.This corrective action will be monitored by:Compliance will be monitored by the Administrator and reported to the QA Committee for at leaset [6] months.	10/03/2012

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	deficient practice could affect residents in the main dining room which has the capacity of seating 44 residents and kitchen staff. Findings include: Based on observation with the Administrator on 09/04/12 at 3:20 p.m., the kitchen K-class fire extinguisher lacked a placard. Based on an interview with the Administrator at the time of observation, the kitchen K-class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 1 of 1 fire extinguishers at the 100 hall nurse' station each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10,			

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	Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect any of the 25 residents in the 100 hall. Findings include: Based on observations with Administrator on 09/04/12 at 3:02 p.m., the monthly inspection tag for the 100 hall nurses' station fire extinguisher lacked documentation of a monthly inspection for months of June through August 2012. This was acknowledged by the Administrator at the time of observation. 3.1-19(b)			

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